National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

PUBLIC HEALTH SPEAKS

UPSTREAM ACTION ON FOOD INSECURITY

Food insecurity is a social determinant of health and contributes to health inequities across Canada. Food insecurity negatively affects all aspects of health - physical, mental, social, emotional – and has implications for the rising cost of healthcare in this country. Over 4 million Canadians are affected by food insecurity, including 1 in 6 children under the age of 18. Rooted in material deprivation, poverty is the biggest predictor of food insecurity. Social policies that improve the material circumstances of households who live with deprivation have been shown to help those who are food insecure. Despite this, the reduction of food insecurity rates has not been an explicit goal of public policies in Canada up to this point.[1]

The National Collaborating Centre for Determinants of Health engaged with leading public health thinkers and practitioners to explore how public health can move beyond a charity focus to addressing food insecurity and take action through upstream solutions. Our contributors were interviewed over the phone, and while everyone was asked the same questions, the interviews did not happen all together as one group. Responses have been laid out to simulate a group conversation, and have been edited for length and clarity. Suggestions for public health roles that arose through the discussion are highlighted.

> "The prevalence, severity and impact of household food insecurity is a serious public health issue in Canada, given the physical and mental health consequences of experiencing household food insecurity. The need for solutions to eliminate household food insecurity is great."[2]
>
> DIETITIANS OF CANADA, 2016

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The Food & Agriculture Organization of the United Nations defines "food security" as when "all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life." This is an aspirational concept and not the focus of this document.

Health status of Canadians 2016: Report of the Chief Public Health Officer for the first time refers to "food insecurity" as a determinant of health (versus "food security").

Q Let's start by exploring food insecurity as a social determinant of health equity. Tell me your perspective.

A CATHERINE – Household food insecurity is an indicator of a household's overall economic wellbeing. It refers to inadequate or insufficient access to food because of financial constraints. When societies have an unequal distribution of wealth or access to resources or capacity, these are policy decisions, and that is what produces food insecurity. Household food insecurity is also a determinant of health in and of itself: it is associated with poor health outcomes.

MELANIE - Through income, it puts it into the equity issue of people not having equal access to food due to economic constraints. And in a lot of cases it's poverty. Those people who are food insecure may have poor health but then they also have a harder time managing their health conditions, especially because a number of health conditions depend on money for healthy food and money for medications.

LYNDSAY - Food is one piece of health but it interacts with the social connections, with the education, and that's how it feeds into the bigger equity piece. It impacts a lot of the work we do and often we don't even realize it.

CATHERINE - When we're talking about society as fundamentally unequal, that doesn't seem like something we can tackle in everyday, frontline public health practice. But frontline public health practice can tackle these big issues along with the practical, everyday problems.

Q What is the intersection of current public health interventions that address "food access" and the issue of food insecurity?

A CATHERINE – The concepts involved are not two flip sides of the same thing. Food access/charity programs are not the alternative to having adequate economic and geographic and social access to food, just as food insecurity is not the flip side of food security.

MELANIE - I think part of the issue is that if you're working directly with clients who don't have any food or any money, you know that policy takes a long time. An immediate thing you can do to help that person eat is help them get to a food bank. The charity piece is what people view as an immediate response and it's what people know. But food insecurity is a long-term problem that requires policy change and policy takes a lot of time to influence and to change and to measure. So what do you do in the meantime? There are some things others are doing that are more about the income rather than the food. So for frontline providers an example might be to ask if they get their income taxes done so they can be eligible for tax credits like the child tax benefit.

LYNDSAY – Many community supports are really food access programs or food skills programs. Community food programs are useful for increasing access and giving people support, new skills, opportunities to learn, and maybe over time give them resources to help build themselves up. But without more money, it doesn't change the reason why they don't have enough to eat.

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Q What do public health interventions that address the root causes of food insecurity look like? Who needs to be involved?

A LYNDSAY - It's a matter of organizational capacity to address the issue, not just capacity of certain professions or individual positions. Everybody has different skills and if you're not tapping into all those skills, you're missing out. I'm good at community partnership building and networking. One of my colleagues is amazing at planning and looking at the research. So we work great together because she'll bring that research in, and I'll bring the community piece, and we get a lot further ahead because of it. The more we bring people with other expertise in, the stronger the programs are going to be, the stronger our advocacy work is going to be, the stronger everything we do is going to be because we can look at it from so many different lenses.

MELANIE - A lot of the community consultation you do comes up with solutions like having a community garden or mapping out the food bank locations. There needs to be broader education not just at the policy level, but also with community partners. People may not know the solution options beyond what they've already seen. They're doing what they've always been told is the way to do it. If something might help a small percentage of the population for a couple of weeks, it's not actually addressing food insecurity because it's not addressing the underlying issue which is income. Public health needs to help switch the conversation from emergency food needs and food-based programs to looking at the policy side of things. Look to partners to help with advocacy. And while looking at interventions they can also present different options but also be clear on what the intended outcomes are for an intervention.

CATHERINE – The way in which we discuss and understand food insecurity as a society changes the dynamic of what's acceptable at a community level. If we only discuss food insecurity as a matter of food or charity, that becomes the dominant set of solutions and problems. If people talk more about this fundamentally being a policy issue, or about income, it becomes more socially acceptable to talk in that way. This is why enshrining our understanding of these issues in position statements such as the new ones from Dietitians of Canada statement and the Ontario Society of Nutrition Professionals in Public Health is so important; why health equity, and economic equity, needs to be central to public health standards and guidelines. Even subtle shifts in social norms shift all of the action possibilities a little.

LYNDSAY - Outside of public health are the partners you least expect. The more you can build those relationships, the more things go back and forth. It's breaking down those doors, spending some time in economic development, spending some time in employment and social services and really understanding what the workers have to do when these clients are coming in, the regulations, and why things are the way they are. Maybe try working with the planning department to understand why they're making the decisions they are and what do we need to do to influence that. There's so many areas within local government where we can learn a lot about how to be able to better position what messages we want. I think it helps us to be able to influence local organizations if they feel like we're a part of it and can be trusted. If you're not out and having those conversations as part of the community, then you miss opportunities and you lose that leverage.

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Q What is needed to support a shift in practice from the current charity focus towards broader solutions to food insecurity?

A MELANIE - We need to start having those conversations in public health. Even though we know we need to address food insecurity, I think the way of going about it is not clear or agreed upon. There is a lot of new research coming out showing that some of the programs public health thought were helping with food insecurity are not. So now we're in a place where we don't want to disregard the community-based food programs because they do benefit communities, but we need to start being clear that they are not addressing food insecurity. So we need to start looking at ways public health and our partners can help address food insecurity.

CATHERINE – Not everyone has the same direct influence on policy, but what is special about public health professional practice is that we all have—and should have—everyday relationships with people working at the frontline, in academia, at the policy level, and in a variety of sectors. We need to make use of these connections. For example, in some of my work, community food security organizations tend to take on more of the advocacy and education at the community level using our research results, and we do the systematic literature reviews or large scale secondary data analysis or intervention studies to inform the tools they put out. So it is that core idea in health promotion of collaboration being the basis of public health practice.

LYNDSAY – People want to feel like they're making a difference, which is what a charity focus allows. We need time to create opportunities to change the discussion, work with partners and leverage our knowledge. We can use provincial organizations or poverty reduction groups that are at arm's length from us to be the ones who say "no, that's not right, and this is why, and here's the research to back it up".

CATHERINE - We need boundary spanners: people who are comfortable speaking in the language of different sectors, and who can do policy brokering as much as possible. We need to think of the diffusion of innovation model where for any kind of new idea or change in process, you're going to have early adopters, the early majority, the late majority, and then the late adopters. Boundary spanners can assess the state of readiness, put it out there across silos, and capture the attention of political, economic, and social policy actors. We need to identify and enable such individuals within organizational mandates. Do you think you're a boundary spanner? Do you have the tools and support to build those bridges from where you are working?

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Q What are some practical actions that public health practitioners can take to address food insecurity?

A MELANIE - Start trying to figure out ways of sharing this with some of those higher level decision-making tables or influencing tables where you can get the conversation shifting. Not just to be talking about food insecurity at the senior level but also recognizing that it's an income piece, all the way up to your Board and CEOs. Movement has to happen from the ground up, but I also think you need those people who are well respected and have a strong voice to help support you in moving it forward and changing the conversation. You might have a champion in your own community but you also need somebody who's a champion and knows how to have that conversation at a provincial level.

LYNDSAY - We need to be a vocal advocate in the community and work to educate partners and the community as much as we can. Our role is prevention, promotion, policy, getting involved with groups who are looking at living wage or basic income guarantee. Sometimes the biggest thing is having the evidence in front of you saying this is what our community needs. Know you're going to stir things up and not everybody's going to be happy with what you're saying. And figure out what the line is between supporting the community but moving the community forward too.

MELANIE - If you are going to try and change the dialogue and start looking at income-based opportunities and advocacy work, you need to consider what kind of language to use, what kind of information to share with people and how to recognize who those key stakeholders are who you're working with in your community.

Q Do you have one final thought you would like to share with public health practitioners and decision-makers?

A CATHERINE - 2016 is the 30th anniversary of the Ottawa Charter for Health Promotion and I think for everybody in public health, it's a great year to go back to the original Ottawa Charter and think about what health promotion really means, what it meant at that time, and what it could mean for the future. Maybe we need a renewal of the idea that at the frontline practice level, health promotion is actually about changing societies and structures and institutions through the small decisions we make every day.

MELANIE - We also have to critically reflect on our work and think about what we're not doing, what we're not measuring, and what we could be doing better. And think about the overall health and health equity that is deserved by everyone. Sometimes it's moving ourselves outside of the immediate situation to looking at the bigger picture and critically reflecting on our practice.

LYNDSAY - The change has to happen. Food access work involves some amazing programs, but they're not going to make broad-level change. We need to celebrate them for what they are, and change the conversation.

A few words about northern food insecurity

The issue of food insecurity in Canada's remote north is multi-faceted, complex, and in many ways distinct from the rest of the country. Northern food insecurity is primarily a challenge for Indigenous people due to the poverty disparity in the north among Indigenous and non-Indigenous people. Multiple compounding factors contribute to a serious crisis-level of food insecurity for non-urban Indigenous communities. Poverty in combination with a decline in animal and plant populations, elevated levels of environmental contaminants in traditional food sources, population increases, hunting quota decreases, increased cost of hunting equipment, harsh climate and negative impacts of climate change, remote locations and weak transportation infrastructure are all factors that point to the need for unique solutions to food insecurity in the north.

See our resource *UPSTREAM ACTION ON FOOD INSECURITY: A CURATED LIST* for resources that explore policy options to address food insecurity, including northern food insecurity.

Shifting the conversation: Potential public health actions for improving health equity related to food insecurity

The National Collaborating Centre for Determinants of Health describes four main roles for public health to act on the social determinants of health and health equity.[3] Several suggestions for various public health action came up in our conversation on food insecurity that align well with these roles. It is hoped that these suggestions will provide public health practitioners with ideas for actions that shift practice towards addressing the root causes of food insecurity as a determinant of health equity.

1. **Assess & report** on the existence and impact of health inequities and effective strategies to reduce these inequities. The following list contains suggestions from our discussion.
    - Evaluate current efforts for longer term effects, such as ability to increase an individual's income through accessing tax benefits or employability.
    - Assess community need by considering local indicators that might point to food insecurity such as low household income, unemployment rates, and rental housing status.
    - Choose outcome indicators to report on in health status reports and to prioritize programs that align with broader equity issues. Canada uses the Household Food Security Survey Module for national reporting. Use this measure if you do a survey on food insecurity and advocate for its regular inclusion in your province's Canadian Community Health Survey content.

2. **Modify & orient interventions** and services to reduce inequities, with an understanding of the unique needs of populations that experience marginalization. The following list contains suggestions from our discussion.

   - Create a list of income-based solutions that public health staff can implement and/or support partners to do, such as strategies to help clients access available income tax benefits that will increase their income (e.g., child tax benefit).

     "Have a list of actions that aren't food based solutions but are income based solutions and actions."

   - Develop key messages about the difference between food access and food insecurity work to support public health staff to communicate with internal and external partners.

     "When we're going out and doing presentations in the community or working with our public health and community partners, we need to make sure that those conversations are coming up every time."

   - Move beyond producing a directory of food access programs.

     "People who access charitable food locations don't need more information about them. We cannot and should not forget if we really want to change people's food access, we need to think about people's economic access."

   - Develop tools and frameworks that incorporate health equity language into practice and program standards to help shift the culture of practice towards more upstream solutions.

     "If all the tools that everybody uses talk about food charity programs, that's not going change their thinking."

   - In a meaningful way, incorporate the lived experience of vulnerable populations in program planning.

     "Make sure there are people with lived experience at the table from the beginning. They have a unique set of knowledge that we need to listen to and take into consideration when making changes to programs."

3. **Partner with other sectors** in government and community to identify ways to improve health outcomes for populations that experience marginalization, in addition to broader initiatives that address systemic influences on the social gradient. The following list contains suggestions from our discussion.

   - Share position statements and tools with partners at all levels to shift the conversation to upstream solutions to food insecurity.

     "Bring tools to the attention of our community groups and get them to buy into it. Have those conversations around what does this mean, why are these documents important and if there's something that doesn't exist around what they're looking for, work with those groups to actually create it."

   - Mobilize knowledge about the impact of food insecurity on health equity and economic implications of working upstream.

     "Share the information with senior leadership and have conversations there about the income piece to try and shift the focus at a leadership level. Whether it's provincial government or municipal government, if you're not having those conversations it's not going to change anything."

   - Talk to funding groups or philanthropic associations about what makes a difference in what gets funded and what doesn't.

     "Shifting some of the language that's used with those funding organizations so that when they're promoting resources out in the community for those applicants that are coming in, the concepts are there."

4. **Participate in policy development** with other organizations in public analysis and development, and advocacy for improvement in health determinants and inequalities. The following list contains suggestions from our discussion.

   - Advocate for implementation of upstream solutions to food insecurity such as the development of a living wage or basic income guarantee.

     "We can advocate. We can make sure that we're having those discussions, and that we're sitting at those tables."

   - Encourage the integration of broader concepts of food insecurity and health equity into provincial program standards and public health practice guidelines.

     "When you have provinces that embed health equity language into public health standards documents, it actually suffuses all of the other policy and program writing and work that comes from it."

   - Compile evidence to support a policy shift towards income-based solutions to food insecurity.

   - Get involved with provincial associations and/or community groups working on basic income guarantee or living wage.

     "We can work with the community groups to make sure that there are no barriers for them. It's advocating for those changes and not stopping advocating just because it hasn't worked yet."

See our resource *LEARNING FROM PRACTICE: ADVOCACY FOR HEALTH EQUITY - FOOD SECURITY* for an example of public health participation in advocacy action on food insecurity.

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Acknowledgements

The interview and resulting document were coordinated, conducted and compiled by Dianne Oickle (NCCDH). Thank you to project advisor Dr. Lynn McIntyre, Professor Emerita at University of Calgary, for her expert input on the scope and direction for exploring this topic and the final product. Thanks to the contributors for sharing their knowledge and experience. All contributors reviewed the draft summary prior to publication.

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Please cite information contained in the document as follows: National Collaborating Centre for Determinants of Health. (2017). *Public Health Speaks: Upstream action on food insecurity.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

ISBN: 978-1-987901-56-6

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centres for Determinants of Health and Healthy Public Policy.

The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

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